Arizona Dept. of Health Services Division of Behavioral Health Services

Encounter Tidbits

Arizona Department of Health Services

November 2003

Encounter Tidbits is a monthly publication of the Arizona Department of Health Services, Division of Behavioral Health Services, Office of Program Support Services
150 North 18th Avenue, 2nd Floor, Phoenix, AZ 85007
www.hs.state.az.us/bhs

HIPAA Corner. . . .

Obtaining Protected Health Information (PHI)

ADHS/DBHS obligations relating to the HIPAA requirement to use, disclose, or request only the minimum amount of Protected Health Information necessary to accomplish the intended purpose of the use, disclosure, or request.

ADHS/DBHS and its workforce members make reasonable efforts to limit individually identifiable health information to that which is minimally necessary to accomplish the intended purpose for the use, disclosure, or request.

The minimum necessary requirement *applies* to:

a. Uses or disclosures requiring the enrolled person to have an opportunity to agree or object;
b. Uses or disclosures that are permitted without authorization, except for those required by law or otherwise specified in the ADHS/DBHS HIPAA Privacy Manual;
c. Uses or disclosures to business associates.

The minimum necessary requirement *does not apply* to:

a. Disclosures to the enrolled person:
b. Disclosures made pursuant to and in compliance with a valid authorization;
c. Disclosures to or requests by healthcare providers for treatment;
d. Disclosures required for compliance with the standardized HIPAA transactions;
e. Uses or disclosures pursuant to an agreement between ADHS/DBHS and the enrolled person for a restriction on the use or disclosure of Protected Health Information;
f. Disclosures made to the U.S. Department of Health and Human Services pursuant to a privacy investigation; or
g. Disclosures otherwise required by the HIPAA regulations or other laws.

As permitted by HIPAA, within the ADHS/DBHS system of behavioral health care service delivery, the Minimum Necessary standard does not apply to routine uses or disclosures of Protected Health Information for treatment, payment and operations including, but not limited to, uses or disclosures related to the following functions as described in the ADHS/DBHS RBHA Contracts and Tribal RBHA Inter-Governmental Agreements, the ADHS/DBHS Policy and Procedure Manual, the ADHS/DBHS Provider Template, or Directives, Performance Improvement Protocols, or documents that provide technical assistance, advice, direction, or instruction to the Tribal and Regional Behavioral Health Authorities and their subcontracted health care providers.

Edit Alerts

An Edit Alert is a faxed and e-mailed notice of system enhancements or changes. The Office of Program Support strives to ensure any system enhancements or changes are communicated to all program participants in an accurate and reliable manner. Edit Alerts will be distributed when the information is first made available and again with the following monthly publication of the Encounter Tidbits.

** There are no Edit Alerts this month **

AHCCCS Pended Encounters

Beginning with the November 2003 Pended Encounter cycle, AHCCCS will only be sending "recycled" pends (records that have not been changed online or processed in the Deletion/Override file). This is your opportunity to clean up all remaining pends from the October 2003 cycle. AHCCCS is targeting January or February 2004 to begin sending new pends again.

Fraud and Abuse Reporting Protocol

DBHS would like to remind all T/RBHA and provider staff's that any allegations of fraud, waste, or abuse must be referred to the Compliance Officer immediately per policy 2.42, Reporting of Fraud and Abuse. DBHS will determine the next course of action for any referred cases. It is also imperative all RBHA employee's, providers, and members, know how and where to report suspicious activity. In addition to reporting fraud at the RBHA level, anyone who wishes to report an incident of suspected fraud and abuse may do so anonymously by calling Stacy Mobbs, DBHS Compliance Officer, at (602) 364-4708 or by e-mail at smobbs@hs.state.az.us.

If you prefer, you may write to us at:

Arizona Department of Health Services/BHS
Stacy K. Mobbs, Compliance Officer
150 N. 18th Avenue, 2nd Floor
Phoenix, Arizona 85007

AHCCCS Encounters Error Codes

H280 – Encounter Not Eligible to Adjust

Encounters are pending because the adjustment submitted does not match the original. Encounters submitted for adjustment must match the provider and client ID numbers from the original encounter. Encounters pending for this reason must be *voided* instead of corrected.

R295 – Medicare Reported But Not Indicated

The Medicare (MDC) Approve and MDC Deduct fields must be blank if the recipient does not have Medicare, otherwise the encounter will pend. If the recipient has Medicare but Medicare denies the service, report zero (0) in the MDC Approve, MDC Deduct, and MDC Paid fields. Please refer to AHCCCS PMMIS system, RP150 Inquire Medicare Coverage screen. This allows Contractors to review the Medicare information that AHCCCS has on file. If you need further assistance, please contact your technical assistant.

Z720–Exact Duplicate Found

Encounters are pending because at least one claim was found in the system that matches the pending claim. These claims need to be researched by the RBHA's to determine the cause for the exact duplicate. Multiple units of service for the same client on the same day need to be combined into one encounter.

Example: A client receives Self-help/Peer service (peer support), per 15 minutes twice in one day; H0038 needs to be billed as one claim with two units instead of two claims for one unit each.

P295 – Service Provider Terminated During Service Date Span

Encounters are pending because the AHCCCS system indicates the billing provider's enrollment status was terminated before the billed dates of service. Providers can check their enrollment status in PMMIS PR070.

Z575 – Date of Service Already Billed on an Outpatient from Different Health Plan

Encounters are pending because the admit hour on an inpatient encounter is before discharge hour on a competing encounter and cannot be overridden. Generally, this is a result of two encounters for one service submitted by two plans. Contact the other plan to determine if there are overlaps in dates of service; and who should have paid for the service or how much of the service. If you need further assistance, contact your technical assistant.

These five errors account for 95.68% of the pended encounters at AHCCCS.

User Access Request Forms

The Office of Program Support Services must authorize all requests for access to CIS, Office of Human Rights, Office of Grievance and Appeals, and PMMIS (AHCCCS) databases. In order to obtain access to any of these databases, please fax a copy of the appropriate User Access Request Form and User Affirmation Statement to Stacy Mobbs at (602) 364-4736. For questions, please contact Stacy Mobbs by telephone at (602) 364-4708 or by e-mail at smobbs@hs.state.az.us.

What is a Corporate Compliance program?

A corporate compliance program is a system designed to detect and prevent violations of law by the agents, employees, officers, and directors of a business.

The existence of an effective compliance plan may provide evidence that any mistakes were inadvertent, and this evidence could be considered by the federal government in determining whether reasonable efforts have been taken to avoid and detect fraud, abuse, or other misbehaviors. A compliance plan also will detect under-coding and improve communication.

The operation of an effective compliance plan demonstrates due diligence and addresses the issue of potential criminal intent.
An effective compliance plan should include the following seven elements:

1. A clear commitment to compliance
2. Appointment of a trustworthy compliance officer with a high level of responsibility
3. Effective training and education programs
4. Auditing and monitoring
5. Effective Lines of Communication
6. Internal Investigation and Disciplinary Processes
7. Response to Offenses, Corrective Action

Documentation must be maintained on the operation of the compliance plan, and accurate patient record documentation is a key component of the compliance plan. Medical record information provides the justification necessary to support claims payment.

Important Definitions for Corporate Compliance

Material violations are defined as a substantial overpayment or a matter that a reasonable person would consider a potential violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized. A material deficiency may be the result of an isolated event or a series of occurrences.

Subcontractor means--

(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement (42 CFR § 455.101).

Knowingly or *knowingly and willfully* means a person, with respect to information -

(a) Has actual knowledge of the information;

(b) Acts in deliberate ignorance of the truth or falsity of the information; or

(c) Acts in reckless disregard of the truth or falsity of the information; and

(d) No proof of specific intent is required (42 CFR § 402.3).

Billing Questions…

General Core Billing Limitations

General core billing limitations include the following:

1. A provider can only bill for his/her time spent in providing the actual service. For all services, the provider may not bill any time associated with note taking and/or medical record upkeep as this time has been included in the rate.
2. For all services except case management and assessment services, the provider may not bill any time associated with phone calls and/or collateral contact with the enrolled person, family and/or other involved parties as this time is included in the rate calculation.
3. The provider may only bill the time spent in face-to-face direct contact; however, when providing assessment or case management services, the provider may also bill indirect contact. Indirect contact includes phone calls and/or collateral contact with the enrolled person, family and/or other involved parties.
4. A provider should bill all time spent in directly providing the actual service, regardless of the assumptions made in the rate model.
5. A professional who supervises the Behavioral Health Professional, Behavioral Health Technician, and/or Behavioral Health Paraprofessional providing the service may not bill this supervision function as a HCPCS/CPT code. Employee supervision has been built into the service code rates.
6. All master's level behavioral health providers will no longer be allowed to bill CPT codes as previously allowed. However, also beginning October 1st, newly-approved HCPCS behavioral health codes will become available to provider types 85, 86, and 87.
7. If the person and/or family member(s) misses his/her appointment, the provider may not bill for the service.

What is a Group Biller?

Any organization may act as the financial representative for any AHCCCS registered provider or group of providers who have authorized this arrangement. Such an organization must register with AHCCCS as a group-billing provider. Under their group biller number, the organization may not provide services or bill as the service provider. Group Billers submit claims and encounters to the RBHA according to established procedures. The RBHA then submits the claims and encounters to ADHS/DBHS. TRBHA subcontracted providers submit claims directly to AHCCCS according to established procedures.

Each AHCCCS registered provider using the group billing arrangement must sign a group billing authorization form and must make sure that their provider ID number appears on each claim even though a group billing number may be used for payment. If a provider has multiple locations, the provider may be affiliated with multiple group billing associations.

Who's Who in the Division of Behavioral Health…..

What is the Bureau of Quality Management and Evaluation?

The Bureau of Quality Management and Evaluation assumes responsibility for quality assessment and continuous quality improvement, utilization review, risk management and development of outcome measurement reports. The Bureau Chief chairs statewide monthly meetings of RBHA QM Coordinators to recommend, review and implement standards of care and practice guidelines.

Data Validation Study Contract Year 01/02

The Data Validation Study CY 01/02 is well underway with the collection of medical records reaching an end. The due date for all records to be submitted to AHCCCS is November 5, 2003. Thanks to everyone for their promptness in the submission of their records. The record collection process was improved this year with the addition of the "records stored at" column on the AHCCCS provider address spreadsheet. We will keep you informed as the Data Validation Study continues.

Office of Program Support Staff

If you need assistance, please contact your assigned Technical Assistant at:

Stacy Mobbs	Gila River Navajo Nation Pascua Yaqui	(602) 364-4708
Michael Carter	NARBHA PGBHA	(602) 364-4710
Eunice Argusta	CPSA-3 CPSA-5	(602) 364-4711
Javier Higuera	Excel Value Options	(602) 364-4712